American Journal of Public Health

Reviewer: E. Abdoler

Title: Lack of health coverage among US veterans from 1987 to 2004

First Author: Himmelstein, DU

Citation: American Journal of Public Health 2007; 97: 2199-2203

Summary: In this study, the authors utilize two recent national surveys to assess the degree to which US veterans are uninsured. While acknowledging that their analysis has several limitations, the authors report that 4.7% of the uninsured population has veteran status, that current trends indicate a modest decline in the degree to which veteran status guards against a lack of health coverage, and that uninsured veterans experience health care access problems that mirror those of other uninsured Americans. In conclusion, the authors opine that more than just a reform or expansion of the VA health care system is necessary to correct the problem of uninsured veterans.

Reviewer: E. Abdoler

Title: Racial/ethnic differences in the development of disability among older adults

First Author: Song, J

Citation: American Journal of Public Health 2007; 97: 2209-2215

Summary: In this study, the authors utilized data from a nationwide survey of noninstitutionalized retirement-age adults to assess the extent to which differences in the prevalence and development (over a six year period) of disability exist along ethnic and racial lines. The authors determined that retirement-age Hispanics (who preferred to be interviewed in Spanish) and African Americans had a greater chance of becoming disabled than did Hispanics preferring to be interviewed in English or Whites; however, the group also found that a variety of other factors (socioeconomic status, health behaviors, baseline health status, etc.) account for a large portion of the racial/ethnic differences observed.

Reviewer: E. Abdoler

Title: Comparing diabetes prevalence between African Americans and Whites of Similar Socioeconomic Status

First Author: Signorello, LB

Citation: American Journal of Public Health 2007; 97: 2260-2266

Summary: Citing inadequacies inherent in the way previous studies have measured socioeconomic status and thus questioning the validity of such studies' subsequent conclusions that the differential prevalence of diabetes between African Americans and Whites must be genetically based, the authors analyzed a large cohort of socioeconomically-similar adults to determine if racial variation in diabetes risk would remain. After taking covariates into account, the authors found only very modest differences in diabetes prevalence between the two racial groups studied; indeed, they determined that obesity seemed to be a more potent disease risk factor for white women than for any other group. As such, the authors conclude that differing incidences of standard risk factors between African Americans and Whites are the more likely cause of diabetes prevalence differences than any genetic variation along racial lines.

Reviewer: E. Abdoler

Title: Prevalence of HIV infection among inpatients and outpatients in Department of Veterans Affairs health care systems: implications for screening programs for HIV

First Author: Owens, DK

Citation: American Journal of Public Health 2007; 97: 2173-2178

Summary: In this study, the authors conducted random serological sampling in six different VA health care sites as a way to assess whether the prevalence of undocumented HIV infection warrants the implementation of routine voluntary HIV screening (as per the new CDC recommendations and various cost effectiveness analyses). Their findings indicate that the rate of undocumented disease is high enough for routine screening to be implemented, leading them to advocate for this change within the VA health care system. While recognizing that their sample population is not representative of patients in other types of health care systems, they argue that few other systems would be able to conduct such an analysis and should take their findings as support of implementing similar policies.

Reviewer: E. Abdoler

Title: Factors associated with patients who leave acute-care hospitals against medical advice

First Author: Ibrahim, SA

Citation: American Journal of Public Health 2007; 97: 2204-2208

Summary: Utilizing data from the 2002 National Inpatient Sample of the Healthcare Cost and Utilization Project (which includes detailed information on a random subset of US hospital discharges), the authors determined that the rate of hospital discharges taking place against medical advice is 1.44%. Through their analysis, the authors were able to name various predictors of such discharges, including being male, young, or poor. They also found a higher incidence of discharges against medical advice in African American populations (as compared to other racial or ethnic groups), as well as in populations covered by Medicaid insurance. While the authors did discover certain hospital characteristics leading to higher rates of such discharges, they caution that more careful analysis is needed to draw useful conclusions.

Annals of Internal Medicine

Reviewer: Namrata Kotwani

Title: Pay-for-Performance Principles That Promote Patient-Centered Care: An Ethics Manifesto

First Author: SnyderL, Neubauer RL

Citation: Annals of Internal Medicine 2007; 147: 792-794

Summary: The ACP is concerned that the design of pay-for-performance systems will lead to worse care despite measurements that imply good care. Little evidence on program effectiveness or on potential unintended consequences. May lead physicians to neglect the complexity of care; deselection of patients; and result in "playing to the measures."

Archives of Internal Medicine

Reviewer: lev

Title: Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos

First Author: Ortega, AN.

Citation: Archives of Internal Medicine 2007; 167: 2354-2360

Summary: The study compared access to health care, use of services, and health care experiences for Mexicans and other Latinos by citizenship and immigrant authorization status. Undocumented Mexicans and other undocumented Latinos reported less use of health care services and poorer experiences with care compared with their US-born counterparts.

Reviewer: lev

Title: A Randomized Trial of Beta Carotene Supplementation and Cognitive Function in Men

First Author: Grodstein, F.

Citation: Archives of Internal Medicine 2007; 167: 2184-2190

Summary: Clinical trials showed that use of Antioxidant, especially over the long term, confers cognitive benefits.

British Medical Journal

Reviewer: Sachs, Ben

Title: Competition in a publicly funded healthcare system

First Author: Woolhandler, S

Citation: British Medical Journal 2007; 335: 1126-1129

Summary: With some in Britain pushing for market-based reforms of the National Health Service, Woolhandler and Himmelstein offer this warning, "The poor performance of US health care is directly attributable to reliance on market mechanisms and for-profit firms and should warn other nations from this path."

Reviewer: Sachs, Ben

Title: Financial ties and concordance between results and conclusions in meta-analyses: retrospective cohort study

First Author: Yank, Veronica

Citation: British Medical Journal 2007; 335: 1202-1202

Summary: The objective of this study was to determine "whether financial ties to one drug company are associated with favourable results or conclusions in meta-analyses on antihypertensive drugs." The distinction between results and conclusions is important here. The results are, essentially, the statistics that the computer spits out, while the conclusions are the humanly-imposed interpretationa of those statistics. What the authors found is that industry funding had no effect on results, but had a profound effect on concusions. Industry-sponsored researchers are likely to put a positive spin on neutral data, while independent researchers, in general, don't spin the data at all.

Reviewer: Sarah Lieber

Title: Swiss hospitals admit to allowing assisted suicide on their wards

First Author: Annette Tuffs

Citation: British Medical Journal 2007; 335: 1064-1065

Summary: "The University Hospital in Bern, Switzerland, admitted last week that an assisted suicide of a terminally ill patient took place on its premises in April 2007. The hospital's management and its ethics committee sanctioned the assisted suicide of a patient with cancer who was too ill to be transported anywhere else, a hospital spokesperson said. The rules in Switzerland? Helping terminally ill patients commit suicide is not illegal; policy varies from hospital to hospital. Most hospitals have guidelines requiring the assessment of a patient's mental capacity. Also assisted suicide can take place in a hospital only if it is impossible for the patient to be taken home or to other private settings (but the suicides themselves are performed by outside organizations such as Exit and Dignitas). This discussion gives rise to question of "suicide tourism": one Swiss organisation, Dignitas, is prepared to offer its services to people who live outside Switzerland. Recent controversy in news when Dignitas helped German people commit suicide in their cars in a Swiss park. Dignitas responded saying that "it respected the wishes of its customers to die wherever they choose, even if this was on a park bench"

Reviewer: Persad

Title: Children, Gillick competency and consent for involvement in research

First Author: Hunter, David

Citation: British Medical Journal 2007; 33: 659-662

Summary: Discussion of whether UK standards for when a minor is competent to accept or refuse medical treatment should extend to research, and who should assess this competency in research settings. Argues that the medical treatment standard is generally inapplicable to research.

(Really from J Med Ethics.)

Reviewer: Persad

Title: Uncomfortable implications: placebo equivalence in drug management of a functional illness

First Author: Hungin, APS

Citation: British Medical Journal 2007; 33: 635-638

Summary: Interesting analysis of counterintuitive ethical implications of placebo prescribing restrictions.

(Really from J Med Ethics)

Reviewer: Sachs, Ben

Title: Influence of pharmaceutical funding on the conclusions of meta-analyses

First Author: Epstein, Richard

Citation: British Medical Journal 2007; 335: 1167-1167

Summary: In this comment on the Yank et al study (see this issue of BMJ), University of Chicago law professor Richard Epstein advocates a conservative response to the bias that Yank revealed. We could, he concedes, respond by prohibiting private industry from directly sponsoring clinical studies. This would probably improve the quality of clinical research, but would also reduce the quantity. Since Yank's study indicates that the results of meta-analyses sponsored by industry are unbiased, and the results themselves are publicly available, there is a way around the problem of biased conclusions: we can draw our own conclusions from the results.

Reviewer: Sachs, Ben

Title: Should drugs be decriminalised? No

First Author: Califano Jr., Joseph A.

Citation: British Medical Journal 2007; 335: 967-967

Summary: Califano holds that, because of their danger, we should want people not to take drugs. Since decriminalization of drugs will increase drug use, we should oppose it. Furthermore, we should support broader use of prevention programs that have been shown to work.

Reviewer: Sachs, Ben

Title: Is infant male circumcision an abuse of the rights of the child? No

First Author: Patrick, Kirsten

Citation: British Medical Journal 2007; 335: 1181-1181

Summary: Patrick, a former Roger Robinson editorial registrar, argues that infant male circumcision isn't particularly risky when performed by a competent person and isn't particulalrly painful when performed under anesthesia. Furthermore, it has protective effects with respect to various STIs. (With regard to penile sensitivity, Patrick says nothing.) Therefore, Patrick argues, male infant circumcision is just as legitimate as immunization.

Reviewer: Sachs, Ben

Title: Mental Capacity Act 2005

First Author: Alonzi, Andrew

Citation: British Medical Journal 2007; 335: 898-898

Summary: On October 1 the Mental Capacity Act 2005 took effect in Great Britain. The act requires doctors who are dealing with patients unable to make decisions for themselves to employ a best interests standard in deciding how to treat the patient. Furthermore, it instructs doctors on how to determine both whether a patient is incapacitated and what that patient's interests are. Interestingly, the incapacitated patient herself is to be consulted, if possible, as are other people who know about the patient's wishes and values. The Act stipulates that the making of an unwise decision is not to be taken as proof that a patient is incapacitated.

The authors of this editorial support the Act.

Reviewer: Sarah Lieber

Title: WHO reports growing commercial trade in transplant organs

First Author: Roger Dobson

Citation: British Medical Journal 2007; 335: 1013-1013

Summary: The WHO just released in November a report on transplant tourism (defined as “traveling abroad for organ transplants provided on a commercial basis”). Report finds that transplant tourism may account for “at least one in 20 of all transplants.” The report gathered its data from “media reports, journal articles, conference papers, reports from health ministries, national transplant registries, and other documents.” The findings: "The total number of recipients who underwent commercial organ transplants overseas may be conservatively estimated at around 5% of all recipients in 2005." Advertising for package deals including a transplant are common and increasingly more popular. A large proportion of organs from countries including “Bolivia, Brazil, Iraq, Israel, Peru, Turkey, and Colombia” are going to foreigners. For example, The Voluntary Health Association of India estimates that about 2000 Indians sell a kidney every year. In Columbia, the report says, 69 out of 873 organ transplants were performed for foreigners. In terms of “outcomes of kidney transplants performed for non-local residents” there is increased frequency of “medical complications, including the transmission of HIV and hepatitis B and C viruses.”

Reviewer: Sarah Lieber

Title: Abortion round the world

First Author: Hannah Brown

Citation: British Medical Journal 2007; 335: 1018-1019

Summary: The Women Deliver conference in London, reported that numbers of abortions have fallen considerably in developed countries; however, abortions are going up in developing due to strict laws banning the procedure. But this leads to more complications, botched operations, and deaths. "Abortion is lowest where contraception and safe, legal, abortions are universally available.” Question of whether legality of procedure can alleviate health burden? Major abortion declines have occurred in countries where abortion is legal but not in countries where abortion is restricted. Simply making abortion legal does not guarantee the drop in procedures and does not guarantee safety. Restrictive abortion laws in many countries are partly to blame but women are still unable to get abortions even when it is legal. Interesting new study of physician attitudes in Brazil: Although most doctors agree that women should be able to have an abortion if they need one, far fewer medical professionals are prepared to perform the procedure. Report suggests that these attitudes serve as barrier to access to abortion services in countries where they are available and legal.

Reviewer: Sarah Lieber

Title: Child wellbeing and inequalities in rich countries

First Author: M E Black

Citation: British Medical Journal 2007; 335: 1054-1055

Summary: Interesting editorial on child wellbeing. Recent Unicef report ranked the wellbeing of children in 21 rich countries. “The report aggregated national data on more than 40 indicators from credible sources in six dimensions:” 1) material wellbeing, 2) health and safety, 3) educational wellbeing, 4) family and peer relationships, 5) behaviours and risks, and 6) subjective wellbeing (how the child sees his or her self). United States and the United Kingdom were in the bottom five countries for five of the dimensions. In this issue of BMJ, Pickett and Wilkinson try to explain Unicef’s results by combining measures of wellbeing with national data on income. Results: “lower scores of wellbeing were seen right across the board for children in the lowest income groups.” The editorial defines wellbeing as “the state of being happy, healthy, and prosperous” and comprises more than just being healthy. Health policy implications? The editorial urges investment in children who worse off. More specifically we need “a coordinated and integrated country-wide response that makes evidence based changes in social and economic policies; improves living and working conditions; and strengthens the health of communities and individuals, via social networks and effective healthcare interventions.”

Reviewer: Sarah Lieber

Title: Controversial embryo bill receives second hearing in Lords

First Author: Lynn Eaton

Citation: British Medical Journal 2007; 335: 1069-1069

Summary: Government’s human embryology and fertilisation bill had its second reading in the House of Lords this week. Interesting implications for lesbians: “bill drops the requirement that fertility specialists, when considering whether a woman is suitable for fertility treatment, have to take account of the need of the child for a father.” Its removal speaks to government’s concern that the clause could be discriminatory in “the provision of goods and services.” The bill also recognizes same sex couples as legal parents (in agreement with current law on “civil partnerships”). Concerns raised by the Lords? This new bill might enable lesbian couples to have fertility treatment more easily. Other concerns about children being brought into the world without a father. Other provisions in the bill: all embryos, whether inside or outside the body, are covered by regulation. “The existing law covers only human fertilisation and does not adequately cover emerging processes for creating embryos.” It allows the creation of "interspecies embryos" for research purposes (“whereby the nucleus of a human somatic cell is implanted into an animal cell from which the nucleus has been removed”). Concerns were also expressed about the creation of interspecies embryos.

Reviewer: Sachs, Ben

Title: Is infant male circumcision an abuse of the rights of the child? Yes

First Author: Hinchley, Geoff

Citation: British Medical Journal 2007; 335: 1180-1180

Summary: Hinchley, an "accident and emergency consultant" (whatever that means), argues that infant male circumcision is painful, dangerous and reduces penile sensitivity. He concedes that it might lower the risk of contracting AIDS, but since that risk presents itself later in life, there is no need to circumcise infants. As to the claims for freedom to practice one's cultural and religious traditions, Hinchley points out that such considerations eventually took a backseat to health concerns in the case of female circumcision. Therefore, he concludes, they ought to take a backseat in the case of male circumcision.

Reviewer: Sachs, Ben

Title: Hepatitis B Vaccination

First Author: Pollard, Andrew J.

Citation: British Medical Journal 2007; 335: 950-950

Summary: In this editorial, the British Medical Association calls upon the UK Department of Health to add the hepatitis B vaccine to the primary immunization schedule for infants.

Reviewer: Persad

Title: Efficiency and the proposed reforms to the NHS research ethics system

First Author: Hunter, David

Citation: British Medical Journal 2007; 33: 651-654

Summary: People are proposing reforms to the NHS system of research ethics committees (analogous to IRBs here). Article criticizes these reforms as untested and as raising fairness concerns.

Reviewer: Sachs, Ben

Title: Should drugs be decriminalised? Yes

First Author: Chand, Kailash

Citation: British Medical Journal 2007; 335: 966-966

Summary: Chand supports the decriminalization, regulation and taxation of drugs on the grounds that it will "halve the prison population, prevent burglaries and prostitution, rip the heart out of organised crime, and free up millions of hours of police time."

Hastings Center Report

Reviewer: Namrata Kotwani

Title: Old Enough

First Author: Orr RD, Craig D

Citation: Hastings Center Report 2007; 37: 15-16

Summary: Two opposed viewpoints on whether minor (adolescent) Jehovah' Witnesses' refusal to receive blood products should be treated as voluntary, informed consent by their doctors.

Reviewer: Namrata Kotwani

Title: The Therapeutic Misconception at 25: Treatment, Research, and Confusion

First Author: Kimmelman, j

Citation: Hastings Center Report 2007; 37: 36-42

Summary: Claims that scholars are contrasting research and clinical care in a too stark fashion, and this seems to be unwarranted. Clinicians also have interests that compete with their therapeutic obligations (medical education, withholding antibiotics, risks to organ donors, triage). Providing care could be a secondary goal of research. These therapeutic goals can influence research design. Further, interpreting therapeutic misconception as the "mistaken belief by research subjects that research projects will directly benefit them," and strays too far from the original definition: "research imposes practices on investigators that conflict with traditional ways of practicing medicine." This new interpretation "flirts with excusing physicians from ethical commitments [unconvincing]."

Reviewer: Namrata Kotwani

Title: Federalism and Bioethics: States and Moral Pluralism

First Author: Fossett JW, Ouellette AR, Philpott S et al

Citation: Hastings Center Report 2007; 37: 24-35

Summary: Authors posit that 'state activism' in bioethics in legislation and implementation of bioethics policy is not a 'bad thing.' Present the 'normative case' for state involvement and present empirical cases where the federal system makes decisions about bioethical issues. Currently, there is a strong preference for national uniformity in regulation. However, "primary locus of regulation" has remain with the states (eg Cruzan, Glucksburg, Quill, Tarasoff, and Schloendorff). The authors argue that the American system for resolving bioethical disputes is largely 'accidentally' determined. State that three factors favor a more federal approach, instead of attempting to formulate uniform policies: moral pluralism (permits local majorities to adjudicate when national consensus is absent); access to decision-makers (local governments are much better at discerning the wishes of their jurisdictions, "venue shopping" has mitigated the adverse effects of federal regulation on research and industry); and the leeway to experiment in policy design and implementation (tailoring of program management to local conditions allows other states and federal govt. to gain information on what works). Case studies: Embryonic stem call research and Plan B.

Reviewer: Namrata Kotwani
Title: Scrutinizing Global Short-Term Medical Outreach
First Author: Decamp M
Citation: Hastings Center Report 2007; 37: 21-23
Summary: Article urges formal ethical guidelines regarding international short-term medical outreach in deprived areas. Asks health workers to critically examine whether their contribution is actually altruistic, potentially harmful, and/or a responsible use of resources.

Reviewer: Namrata Kotwani
Title: What I Learned from Schiavo
First Author: Witherspoon GS
Citation: Hastings Center Report 2007; 36: 17-20
Summary: Essay which discusses the benefits and limitations of advanced directives.

Reviewer: Namrata Kotwani
Title: Protecting Women from Their Abortion Choices
First Author: Dresser, R
Citation: Hastings Center Report 2007; 37: 13-14
Summary: Revisits cases on abortion and claims that it is disingenuous to “portray abortion bans and mandatory disclosures of one-sided information as policies protecting women.”

Health Affairs

Reviewer: lev
Title: Reframing The Debate Over Health Care Reform: The Role Of System Performance And Affordability
First Author: Thorpe, KE
Citation: Health Affairs 2007; 26: 1560-1562
Summary: This paper suggests that since 85 percent of Americans have health insurance, framing the debate around the affordability of coverage would be important to making a health reform possible. The paper also suggests that understanding the factors responsible for driving up health costs is crucial. He argues that much of the rise in spending is linked to the rise in the prevalence of treated disease—much of which is preventable. Reform strategies that address this issue are not inherently partisan and may prove to be a fruitful starting point for launching the debate.

Reviewer: Lev

Title: What Are The Prospects For Enduring Comprehensive Health Care Reform?

First Author: Fuchs, Victor R.

Citation: Health Affairs 2007; 26: 1542-1544

Summary: This paper discusses the obstacles that prevent a comprehensive health reform: "special interests," especially as they exploit the U.S. political system; Machiavelli's Law of Reform, which favors the status quo; and the inability of reformers to agree on a common approach. It then looks at prospects in three dimensions: short-term prospects for enduring comprehensive reform are very low. Over five to ten years, prospects are fifty-fifty unless there were a major economic, political, social, or public health crisis. In the long run, major reform is inevitable.

Reviewer: lev

Title: The Promise Of Health Care Cost Containment

First Author: Garber, A

Citation: Health Affairs 2007; 26: 1545-1547

Summary: This paper discusses ways in which health care costs might be reduced without negatively influencing quality of care. The health literature cited suggests that spending could be reduced by as much as 30 percent without adversely affecting health.

Reviewer: lev

Title: The New Architects Of Health Care Reform

First Author: Schaeffer, L.

Citation: Health Affairs 2007; 26: 1557-1559

Summary: This article discusses the rising health care costs and its dangers.

JAMA

Reviewer: O'Neil

Title: Dementia Screening in Primary Care: Is it Time?

First Author: Brayne, Carol, et al.

Citation: JAMA 2007; 298: 2409-2411

Summary: Systematic screening by age would enable earlier detection of dementia. Earlier detection offers a number of advantages: earlier treatment, earlier (and more competent) decisionmaking about arrangements for future care, etc. But those who are detected by screening may not wish to be diagnosed for a variety of reasons (e.g., fear of losing their driving license, their independence, their insurance). Since screening costs money that might be better spent elsewhere and since the treatments currently available do not more than slow down the progress of the disease, systematic screening is not yet a good idea.

Reviewer: O'Neil

Title: The Reemerging HIV/AIDS Epidemic in Men Who Have Sex With Men

First Author: Jaffe, Harold W., et al.

Citation: JAMA 2007; 298: 2412-2414

Summary: HIV cases have increased recently. The cause seems to be an increase in the frequency of unprotected sex--the availability of antiretroviral therapy has made unprotected sex more attractive by making people less afraid of AIDS. We could exaggerate the dangers of AIDS in order to scare people into using condoms. But the authors reject this proposal on liberal grounds. Instead they suggest that since people who know they are infected with HIV are less likely to have unprotected sex, we should try to increase HIV testing rates through screening.

Reviewer: O'Neil

Title: Asymmetric Paternalism to Improve Health Behaviors

First Author: Loewenstein, George, et al.

Citation: JAMA 2007; 298: 2415-2417

Summary: Traditional econ assumes that agents are rational. But we are not--we are, among other things, irrationally biased in favor of the present. We smoke, drink, and overeat because these activities are immediately gratifying and their costs are delayed. And we refuse to exercise and take our medicine because these activities are immediately inconvenient or costly and their benefits are delayed. Asymmetric paternalism is any policy that, without making any options off limits, exploits our decisional biases to promote healthy rather than unhealthy behavior. Putting healthy food before unhealthy in a cafeteria or making soda machines hard to find exploits our bias in favor of immediate benefits and against immediate costs. Getting people to make enforceable commitments to diet or save money in the future is easier than getting them to diet or save money now since the costs of making a commitment are delayed. And it is well-established that giving drug users small cash incentives for abstinence is a highly effective way of promoting abstinence. The cash incentives make the rewards for abstinence more tangible and immediate.

Reviewer: O'Neil

Title: Persistence of Contradicted Claims in the Literature

First Author: Tatsioni, Athina, et al.

Citation: JAMA 2007; 298: 2517-2526

Summary: The authors looked at three prominent claims--that vitamin E is beneficial for cardiovascular disease and cancer, that beta-carotene is effective for cancer, and that estrogen is beneficial for Alzheimer's dementia--that were based on observational studies and later refuted by randomized studies to determine the extent to which the refutations killed off the original claims. After the refutations there was a decrease in the proportion of favorable citations of these claims, but a high percentage remained favorable. Many who made favorable citations did not mention the later randomized studies. Those who did mention the randomized studies raised a bewildering variety of objections to those studies that suggested the influence of wishful thinking.

Journal of Clinical Ethics

Reviewer: Sarah Lieber

Title: Legal Trends in Bioethics

First Author: Sigrid Fry-Revere

Citation: Journal of Clinical Ethics 2007; 18: 294-328

Summary: General summary of new cases/laws relating to specific topics:

On pre-birth issues (sex, fertility, contraception, abortion, fetuses, embryos, and stem cells): recent Texas case w/ potential to decide that frozen embryos are persons with right to life; as abortion laws get stricter in US, in foreign countries the restrictions are getting looser (e.g. Alabama just introduced 3 new bills in legislature to restrict abortions vs. abortions being legalized for first time in Mexico City); federal case: no state can allow partial-birth abortions unless it is to save life of woman;

On after-birth issues (premature infants, newborns and children): discussion of parental consent and notification laws (e.g. more than half of US states require parental consent before a minor can get a tattoo or piercing. In some of these states, no such consent is required for an abortion); Missouri law allows midwives to deliver infants at home

On vaccines: cases/laws discussing mandating the HPV vaccine; conflict b/w mandatory childhood vaccines advocated by govt and pharmaceuticals and parent's objections (on religious, moral grounds, or distrust of govt.)

On informed consent: Interesting discussion of disclosure requirements and what are reasonable expectations, on parts of patients, for disclosure. When disclosure requirements are clear, can providers be held liable if patient suffers from unanticipated adverse events? U.S. Supreme Court granted certiorari in a case in which a medical device manufacturer's defense is that it should not be held liable for the plaintiff's injuries because it complied with labeling requirements of FDA.

On life and death decisions: interesting case on medical tourism and Canadian law forbidding individuals to travel to countries like Switzerland where euthanasia is not illegal. In U.S., however, clear constitutional right to travel; Abraham's Law in Virginia March 2007: finds that a child 14 or older is "sufficiently mature to have an informed opinion on the subject of his medical treatment" and can refuse treatment when suffering from a life threatening situation if their parents agree;

On the right to access and control medical information (privacy, discrimination etc.): new cases/ laws discussing disclosure of genetic testing several lawmakers introduced legislation to prevent genetic discrimination

On HIV: loosening of informed-consent requirements in some states; mores states are requiring HIV testing in a larger variety of situations.

On conscientious objection (healthcare providers etc): conscientious objector laws have roots in First Amendment free exercise clause: generally an accommodation for those who raise a conscientious objection must be made unless their exercise of that freedom would directly put someone else at risk. Legislation tackling this issue on grounds of contract and notice: health care providers can contract to have their moral views on certain issues respected by not requiring that they perform certain procedures etc, but patients need to be given notice of t he provider's position, etc.

Reviewer: Sarah Lieber

Title: Decision-Making Capacity, Memory and Informed Consent, and Judgment at the Boundaries of the Self

First Author: Omar Sultan Haque

Citation: Journal of Clinical Ethics 2007; 18: 256-261

Summary: Authors claim that in this case, despite the short-term memory loss, decision-making capacities may be possible. “In general, his long-term and remote memory (from which he might derive access to his lifelong values and goals) are intact”. He is able to reason, communicate, and understand the proposed treatment and the risks and benefits of declining treatment. His mental state is stable over time (even though he loses memory w/in 1 hr). Another factor that needed to be further assessed was potential for memory recovery. The patient was able to understand and summarize what he had learned about his cancer and treatment options—normally a surrogate decision maker isn’t called upon when a patient can do this. The authors claim that the surrogate may not have been necessary especially since healthcare providers allowed the patient to make the decision to designate the brother as a proxy, and to give his daughters access to his medical records. Why not then allow him to decide his course of treatment?

Reviewer: Sarah Lieber

Title: What Families Say about Surrogacy: A Response to "Autonomy and the Family as (In)appropriate Surrogates for DNR Decisions"

First Author: James L. Nelson

Citation: Journal of Clinical Ethics 2007; 18: 219-226

Summary: Response to previous article. Summary of previous article: "different patients and members of their families have different understandings of the nature, scope, and justification of families' roles in the decision to perform CPR….These results are taken to support a policy of diversity in approaches to medical decision making." Authors of this article criticize previous article for a single-minded focus on autonomy which prevents them from doing good work in looking at issues surrounding families, decision-making and end-of-life care.

Some criticisms:
1) unclear whether patients were asked about the current role of family members in decision-making process, or how family members should act.
2) fixation on autonomy makes us fail to raise questions about context—for example, CPR assumed to be default option in study. But why? Given that survival rates for cancer patients who receive CPR after an in-hospital arrest are pretty low, why are cancer patients being presented with fewer than 3 months to live presented with a DNR decision at all?
3) were patients even explained the slim chances of survival and physical trauma attributed to CPR?
4) the idea of a person being part of a social network should NOT be subsumed under the concept of autonomy—best-interests standard for proxy decision making mistakenly characterized as an autonomy-motivated standard; however, really invoked when no autonomy exists. It may just be the case that some patients don't value their self-determination (i.e. expression of true autonomous choice) and rather believe in shared agency and cooperative decision-making processes involving family members. "We think the autonomy-driven analysis has produced a distorted understanding of what the subject of the interview is doing.
5) the role of family is over-simplified—not just there for treatment decisions. Families play a huge part in maintaining patient's identity: "By interacting with patient in familiar ways, being with her as she enters unfamiliar territory, and keeping her nested within the web of intimate relationships that sustain her, family members remind the patient of who she has been and help her to continue to be it." There should be more discussion of shared and proxy decision making situated within the full range of responsibilities family members assume.

Reviewer: Sarah Lieber

Title: Harvard Medical School Public Forum: Insuring the Uninsured: Does Massachusetts Have the Right Model? 17 May 2007

First Author: Lisa Lehmann (moderator)

Citation: Journal of Clinical Ethics 2007; 18: 270-293

Summary: Forum on healthcare reform and Massachusetts healthcare legislation with speakers: Katherine Swartz, Michael Chin, Marcia Angell, Norman Daniels, Dan Brock, Rashi Fein etc.

Background: problem of 45 million uninsured in America; 536,000 in MA uninsured. 30% of uninsured are middle class (income b/w about $30,000 and $46,000). 3 in 5 of young adults are uninsured. 1 in 6 non-elderly Americans uninsured. Since early 80's, huge decline in the number of manufacturing jobs (22% 10%) meaning that people without jobs don't have employer-based health insurance and their families aren't covered either. These younger populations got jobs in the service sector (primarily smaller private businesses which are less likely to offer HI). Also changes in employee-employer relationship with more self-employed and "contracted" employees (technically not employees or wouldn't have been hired in that line of work). Between 1980-2005, accounting for inflation, cost of healthcare per capita almost tripled (no doubt employers do NOT want to pay for HI for workers). These factors create pressure on country to provide public programs that will support private insurance markets and expand access to those markets.

In the individual insurance market, "non-group" health insurance provided at high premiums. Problem of adverse selection and unhealthy individuals or individuals who know something bad about their medical history more likely to purchase.

MA response: July 2007 policy mandating that all residents in MA legally required to have health insurance or fined. Thought this would resolve problem of adverse selection and state would subsidize coverage for low income individuals. Healthcare reform programs consist of Commonwealth Care (subsidized health insurance), Commonwealth Choice (non-subsidized), young adult plans (19-26; fewer benefits but lower prices), MassHealth expansions (Medicaid in MA), etc.

Interesting idea of shared responsibility articulated in describing MA policy responsibility of individuals, state, employers, etc.

Problems noted by speakers (mainly Marcia Angell): individual mandate is harsh and inequitable (the poor have to pay much higher % of their incomes on healthcare than more affluent); older, sicker patients will also pay more doesn't seem like responsibility is really "shared" but disproportionately burdening poor, sick, and old; right above poverty line individuals not subsidized by govt.; hefty fine if don't enroll in insurance plan (half premium of lowest priced plan); cheapest plans are least comprehensive so while individuals might have health insurance, not receiving health care; how do we get money to pay for plan?; general problem of trying to expand a faulty system that relies on employers and private insurers. Really need to move to single-payer system.

Problems (specifically noted by Norman Daniels and Dan Brock): Norman Daniels primarily agrees with Angell's criticisms and things the expansion of Medicare and move towards a single-payer system is possible in this country. The main obstacles are political

and failure of leadership to move towards single-payer system. Dan Brock does not think the mandate is harsh or inequitable—like other national health insurance schemes in which there is a shared financial responsibility to pay tax revenues, the mandate also ensures the spread of costs so that there is no free riding, etc. Still doesn't think this is the right model that other states can adopt precisely because MA is a liberal, wealthy state with low uninsured rates relative to other states.

Reviewer: Sarah Lieber

Title: Autonomy and the Family as (In)Appropriate Surrogates for DNR Decisions: A Qualitative Analysis of Dying Cancer Patients' Talk

First Author: Jaklin Eliott

Citation: Journal of Clinical Ethics 2007; 18: 206-218

Summary: In Australia, majority of medical discussion regarding DNR, decision making, and surrogacy reflect a "professional perspective" and not one of patient. Views of dying patients are sparse, especially on subject of surrogacy. It is for this reason conducting qualitative study examining dying cancer patients' perspectives on DNR decision making and the role of family members in surrogacy.
Methods: Subjects were deemed "capable of coherent discussion" and "emotionally stable"; all were in final stages of their illness and assessed by medical oncologist as likely to die within 3 months and were "critically aware" of their prognosis. In taped interviews patients asked open-ended questions about DNR decision making, etc. and in some cases allowed to discuss with present family members the questions. Subjects predominantly white and Christian. Discourse analysts assessed the language and responses.

Results: patient notion of autonomy suggests that it has a relational or social component—"Most participants held that DNR decisions were theirs to make, but the involvement of some family members appeared to be taken for granted." Involvement of family members in decision-making process taken as normal and appropriate—"Most participants reported discussing the issue with various family members, suggesting that family members knew their wishes." But still patient was seen as primary decision-maker, who consulted family, but ultimately had to decide "for him/herself." Some patients saw family discussion as "mandatory" or "obligatory". Keeping family members informed was seen in positive light as benefiting family. Note that other studies suggest that patients consider the overall consequences of their decisions upon family members; however, these findings suggest that patients also consider consequences of not including family members in decision-making process.

Decision-making is not a one way street! Participants also claimed that "consideration of their family members' dissent or disapproval constitutes another factor that patients might legitimately take on board while arriving at their own decision"—these opposing views don't necessarily reflect a misrepresentation of patient's views and wishes, but rather inform the patient's autonomous decision.

Patients who expressed that family members were inappropriate surrogates said this was often the case when 1) family members refused to accept the patient's prognosis and inevitability of death, and therefore refused to admit to having this type of discussion and 2) family members who are TOO emotional involved.

Conclusion: most patients identify themselves as individuals and as part of a social structure, the family. "We argue that respect for the autonomy of the patient dictates that the patient not be coerced to voice a direct preference, but rather that a patient's autonomous choice not to make a decision should be heard and accommodated. This may require increased familial discussion with clinical staff and assurance that appropriate decisions will be made in the best interest of the patient."

Need to develop more flexible policy that accommodates a wide range of patients' and

families' preferences, and does not assume for all cases that the patient is sole decision-maker.

Reviewer: Sarah Lieber

Title: The Challenges of Amnesia in Assessing Capacity, Assigning a Proxy, and Deciding to Forego Life-Prolonging Medical Treatment

First Author: Catherine Myser

Citation: Journal of Clinical Ethics 2007; 18: 262-269

Summary: Assessment of capacity is crucial to the informed consent process of "disclosing information, ensuring understanding and voluntariness, and obtaining consent." More extensive testing by neurology should've been performed to assess the patient's capacity to engage in each one of these steps, and whether capacity could ever be restored. Before assigning proxy need to make sure that capacity cannot be restored in some way. The confusion about the patient's ability to make decisions could've been resolved if more precise neurological, amnesia, and memory evaluation were conducted. Should've sought out the opinions of more clinical experts to get a better picture of decision-making capacity. "short-term memory" conditions vary from patient to patient and in general different types of information can be retained depending on the type of condition—therefore, learning as much as possible about the specific learning and memory capacities of this patient would've been very helpful in this case especially in communicating his prognosis and treatment options.

Reviewer: Sarah Lieber

Title: At the Bedside: How Should Careproviders Respond When the Medical System Leaves a Patient Short?

First Author: Edmund G. Howe

Citation: Journal of Clinical Ethics 2007; 18: 195-205

Summary: The topic: rationing resources in the clinical setting. The article does NOT discuss whether or not providers should be making these decisions. Rather the article focuses on what providers should SAY to patients AND how they should proceed with rationing decisions, given that they do decide to engage in these practices. The main point of the article is to suggest practical ways providers can make rationing decisions that won't enrage patients or undermine provider-patient relationship. All in all a pretty crummy article.

Careproviders are forced to make tough ethical decisions allocating scarce resource. When making triage decisions, provider might have to tell patient that he's making a decision that compromises the patient's best interests. Can providers do this? If so, how? Tension between 1) not making triage decision (perhaps referring) and being committed to patient's best interest vs. 2) making triage decision and perhaps lying by omission to compromise patient's best interests. Author's argument: if careproviders do decide to make triage decisions (and this is open for debate), then "it may be that they should be fully honest about it. It may establish the kind of patient/careprovider relationship, based on trust, that can allow patients to transcend the negative response to the withholding of resource that they otherwise might have."

Main claims: providers should admit to limited resources; they should say they're sorry for providing less than optimal care; they should openly acknowledge "the pain" and remorse they feel for making these kinds of decisions; they should reassure patients that they are the ones who should be making these decisions b/c they know their patients' interests the best; in deciding whether to divulge to patients that a "triage decision" has been made, providers should consider the amount of risk the patient is made to take on by the triage decision in addition to the "physician's anxiety in response to withholding information"; providers should tell their patients when they refuse to "game the system" (go against legal or hospital policies in order to benefit the patient); in making decisions about whether to self-sacrifice in order to meet patient's best interests, providers should consider whether they will have a feeling of regret if they do not make the sacrifice. If likely to feel remorse or regret, probably should make sacrifice. If choose not to self-sacrifice, then should be honest with patient.

Take home messages: be honest, express regret or remorse when make decisions that go against patient's best interests

Reviewer: Sarah Lieber

Title: Case and Commentary: Memento…Life Imitates Art: The Request for an Ethics Consultation

First Author: Sheila Otto

Citation: Journal of Clinical Ethics 2007; 18: 247-251

Summary: Fascinating case of patient with aggressive lung cancer and short-term memory loss. The patient was repeatedly told that he had cancer and had to made choices about how to treat it (an aggressive chemotherapy was the best option). Yet, when the ethics consultant visited him, he had no recollection of this whatsoever. Patient's brother was appointed his healthcare proxy upon admission—based on his knowledge of his brother's values and given the poor prognosis, the brother decided to decline chemotherapy. There were repeated ethics consults—upon each visit the patient had no recollection of why he was in the hospital, did not remember previous consults, and had to be re-told that he had cancer and go through the shock of hearing such news. In each consult would lucidly state that didn't think the chemotherapy was worth it because of the poor quality of life he'd have for such a short period of time.

Questions: how do we respect patient's autonomy? Get informed consent? Appropriately designate surrogate decision maker? How do we know if patient can adequately assess benefits and risks when he cannot remember his own prognosis?

Ultimate decision: discharged to a supportive facility where he received comfort-care. Chemotherapy was not pursued.

Journal of General Internal Medicine

Reviewer: E. Abdoler

Title: Update in health disparities

First Author: Washington, DL

Citation: Journal of General Internal Medicine 2007; 22: 1756-1761

Summary: In this article, the authors provide brief reviews of nine studies (published in 2006) that explore and assess different aspects of health and healthcare disparities within the U.S. The summarized studies were chosen based upon their potential to inform clinical practice and improve the way health care is delivered to various minority populations.

Lancet

Reviewer: Millum
Title: Health inequality in Latin America
First Author: Belizán, J M. et al
Citation: Lancet 2007; 370: 1599-1600
Summary: Summarizes the inequalities in health indicators in Latin America, which reflect high income inequities. Health care in these countries is not organized to address these inequalities. This whole issue of the Lancet focuses on health and research in Latin America.

Reviewer: Millum
Title: UN Declaration on the Rights of Indigenous Peoples
First Author: Stephens, C. et al
Citation: Lancet 2007; 370: 1756-1756
Summary: On 13 November 2007, the UN General Assembly adopted the UN Declaration on the Rights of Indigenous Peoples.

Reviewer: Millum
Title: Benefits and risks of homoeopathy
First Author: Goldacre, B.
Citation: Lancet 2007; 370: 1672-1673
Summary: The author notes that five meta-analyses of homeopathic trials have concluded: “excluding methodologically inadequate trials and accounting for publication bias, homoeopathy produced no statistically significant benefit over placebo.” He suggests that though there might be a role for placebos, the current practice of homeopathy is dangerous.

New England Journal of Medicine

Reviewer: Smith
Title: “The Anatomy of Medical School Patenting”
First Author: Azoulay, P; Michigan, R; Sampat, B
Citation: New England Journal of Medicine 2007; 357: 2049-2056
Summary: Article pooled data on patents applied for and granted to medical school faculty, confirming the claims that the rate of patenting from 1981 to 2000 had increased dramatically. However, “patent activity was concentrated among a small number of departments and faculty members.” Those recently receiving NIH funding were more likely to apply and receive patents than those not.

Reviewer: Smith

Title: In Defense of Pharmacoepidemiology -- Embracing the Yin and Yang of Drug Research

First Author: Avorn, J

Citation: New England Journal of Medicine 2007; 357: 2219-2221

Summary: Article begins with a history of cases in which observational studies have been refuted by later RCTs. The author then argues that the limits of RCTs demand observational studies nevertheless. He claims that pharamacoepidemiologists are beginning to learn from their past mistakes and that people too easily forget the drawbacks of the RCT and the growing pains that went into its methodological formation. He then concludes with two analogies: one between the perspectives of the RCT and observational studies and various perspectives in a Zen garden; and another between the difference in perspectives between astronomy and aeronautics and the difference in perspectives of the RCT and observational studies.

Reviewer: Smith

Title: "The Fate of SCHIP – Surrogate Marker for Health Care Ideology"

First Author: Iglehart, J

Citation: New England Journal of Medicine 2007; 357: 2104-2107

Summary: Article recounts the political divides and ideology behind the SCHIP veto. It looks forward with brief speculation on the coming months for SCHIP programs and the effect that the veto will have on the presidential campaigns.

Reviewer: Smith

Title: "Presidential Politics and the Resurgence of Health Care Reform"

First Author: Oberlander, J

Citation: New England Journal of Medicine 2007; 357: 2101-2104

Summary: Oberlander gives a great summary of the divisions of the different health care proposals by various presidential candidates along party lines. He also gives a good summary of the differences between particular candidates. Good article for those who need an introduction to health care reform.

Reviewer: Smith

Title: Assessment of Patients' Competence to Consent to Treatment

First Author: Appelbaum, P

Citation: New England Journal of Medicine 2007; 357: 1834-1840

Summary: A vignette is offered of a case in which competence to refuse treatment is to be questioned. Appelbaum leads readers through the landscape of consent problems. He then moves to the criteria to assess capacity, the sliding scale assessment of incompetence, various approaches to assessment including the MMNE and the MacCAT, and finally the consequences of finding the patient incapable. He concludes that the patient is likely capable of consent, but that given the severity of this decision the standards in assessment must be high.

Reviewer: Smith

Title: Dengue and Yellow Fever -- Challenges for the Development and Use of Vaccines

First Author: Monath, T.P.

Citation: New England Journal of Medicine 2007; 357: 2222-2225

Summary: Article begins with an overview of the immunological affects and areas that are susceptible to Dengue and Yellow Fever. It continues to discuss the difficulty in developing a Dengue immunization, which primarily stems from the fact that a vaccine would have to develop immunity against four different Dengue serotypes, as well as two live vaccines that are currently in trials. It then moves to a discussion of the history of the yellow fever vaccine and the recent (2001) findings that have brought to light the danger of the currently licensed vaccine. It concludes with a discussion of the decision-making tradeoffs that physicians and travelers will have to undertake when considering the yellow fever vaccine.

Reviewer: Smith

Title: Bolstering the FDA's Drug-Safety Authority

First Author: Schultz, W

Citation: New England Journal of Medicine 2007; 357: 2217-2219

Summary: Article discusses the FDA Amendments Act. It begins by putting the acts birth in historical prospective. It then suggests some the difficulties that will still exist between the OND and the OSE as well as problems in the Adverse Event Reporting System. It discusses the possibilities of the FDA's use of drug-reaction report databases and publication of preliminary findings. It concludes by questioning whether the FDA will be able to use its new teeth given tensions between Congress and the Executive Branch on the issue.

Reviewer: Smith

Title: Statistics in Medicine -- Reporting of Subgroup Analyses in Clinical Trials

First Author: Wang, R; Drazen, J; et al

Citation: New England Journal of Medicine 2007; 357: 2189-2194

Summary: Authors give background on subgroup analyses including the topic of heterogeneity and statistical interactions, the problems that multiplicity of subgroup analyses introdces, and the distinction between prespecified and post hoc analyses. The then give the results of an internal study of the Journal in which the reporting of subgroup analyses found in the Journal between July 1, 2005 and June 30, 2006 was analyzed. The authors found significant inconsistency and insufficient clarity and introduced guidelines for the reporting subgroup analyses in the Journal

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Reviewer: Smith

Title: "Closing the Affordability Gap for Drugs in Low-Income Countries"

First Author: Steinbrook, R

Citation: New England Journal of Medicine 2007; 357: 1996-1999

Summary: Article analyzes the affordability gap between countries of various income levels. It looks at the recent developments in making a number of drugs – particularly ART – affordable in low- and mid- income countries. It pays particular attention to compulsory licensing, a legal means for allowing the use of a patent without the patent holder's permission.

Reviewer: Smith

Title: "The Ongoing Regulation of Generic Drugs"

First Author: Frank, R

Citation: New England Journal of Medicine 2007; 357: 1993-1996

Summary: Article recounts various drug companies' reactions to the Hatch-Waxman Act. These include litigation, price competition among generics, and reformulations of certain products to get new patents. Companies have launched their own "authorized generics" and paying generic companies to delay market entry. The article concludes that reactions should have been expected by policy-makers, but that current congressional debate is addressing the right matters.

Reviewer: Smith

Title: "The Spread of Obesity in a Social Network"

First Author: Tamburlini, G; Cattaneo, A

Citation: New England Journal of Medicine 2007; 357: 1866-1868

Summary: Correspondence on previous article on interpersonal spreading of obesity (July 26, 2007). Tamburlini and Cattaneo object for the lack of assessment of social and economic status determinants in Christakis and Fowler's findings of the interpersonal spreading of obesity. Christakis and Fowler respond that education was published as not showing a significant effect and that they did not report that there were additional analyses taking account of income. Knecht, Reinholz, and Kenning discuss the relationship between Christakis and Fowler's findings and anchoring effects, an assessment with which Christakis and Fowler agree and adds that framing is also shown by their findings. Rosen discusses the extension of these findings (and similar etiological factors, such as smoking) into RCTs, another assessment with which Christakis and Fowler agree.

Reviewer: Smith

Title: "Doctors and Drug Companies – Scrutinizing Influential Relationships"

First Author: Campbell, E

Citation: New England Journal of Medicine 2007; 357: 1796-1797

Summary: Article discusses the Physician Payments Sunshine Act, which targets physician-pharmaceutical company relationships by forcing disclosure by drug companies (with annual revenue of more than $100 million) of the amount they give to physicians. It discusses actions similar actions at state levels, the negative effects of these relationships, action by hospitals and health systems, and the chance that this federal action will be a further impetus for the health industry to self-police. It concludes with suggested action that physicians can take at the individual level.

Reviewer: Smith

Title: "Becoming a Doctor, Starting a Family – Leaves of Absence from Graduate Medical Education"

First Author: Jagsi, R; Nancy, T; and Weinstein, D

Citation: New England Journal of Medicine 2007; 357: 1889-1891

Summary: Article chronicles the difficulties of those in medical training attempting to start families, thus needing parental leave, and to complete their residencies and fellowships on time. The article suggests that new strategies must be implemented to fairly assess these concerns and those of providing sufficient training, future patients of these trainees, and fellow trainees.

Reviewer: Smith

Title: "Climbing through Medicine's Glass Ceiling"

First Author: Andrews, N

Citation: New England Journal of Medicine 2007; 357: 1887-1889

Summary: Nancy Andrews comments upon the lack of women in leadership roles in academic medicine despite the increased number of women in the field of medicine generally, especially deans. She suggests targeting women who have not "stepped on every rung of the traditional academic career ladder." Universities must work harder to identify these women and not make assumptions about sacrifices that women will be willing to make. She points to the changing landscape of corporate world recruitment of women who have taken time for motherhood.

Reviewer: Smith

Title: "Addressing Rising Health Care Costs"

First Author: Orszag, P; Ellis, P

Citation: New England Journal of Medicine 2007; 357: 1885-1887

Summary: This is the second part of a two article series; its companion appears in issue 357, volume 18, under the title "The Challenge of Rising Health Care Costs – A View from the Congressional Budget Office." The article discusses a number of proposed solutions to health-care spending growth. First it considers "generating more information about the relative effectiveness" of various treatments and altering incentives to providers and consumers to increase effective care. The article suggests two problems with this approach: first, a lack of evidence and second, the fact that incentives usually encourage more expensive care. The article suggests expansion of research, increased proportion of payment by plan enrollees, and adjustment of incentive structures. It concludes by discussing the problem of "increasing prevalence of many chronic conditions" to the growth in spending and suggests care-coordination strategies targeting these populations as one strategy for this problem.

Reviewer: Smith

Title: "The Challenge of Rising Health Care Costs – A View from the Congressional Budget Office"

First Author: Orszag, P; Ellis, P

Citation: New England Journal of Medicine 2007; 357: 1793-1795

Summary: This is the first half of a two-article series; its companion appears in issue 357, volume 19, under the title "Addressing Rising Health Care Costs." Article points to the increasing medical spending and the problems that this trend, if continued, will pose for the US. Article notes that the growth "appears to result not from increasing disease prevalence but from the development and diffusion of new medical technologies and therapies." It derides the fee-for-service payment plan as placing incentives on supplying more services. Article also points to decrease in the proportion of spending that is constituted by out-of-pocket spending. Furthermore, the article notes that despite increasing spending, there is little evidence of its promotion of health outcomes; the article then concludes pointing out vast regional disparities in spending independent of other correlations and promises to discuss strategies in an article in the next issue.

PLoS Medicine

Reviewer: Persad

Title: Evolution of Antiretroviral Drug Costs in Brazil in the Context of Free and Universal Access to AIDS Treatment

First Author: Nunn, AS

Citation: PLoS Medicine 2007; 4: e305-e305

Summary: Very interesting discussion of how ARV costs in Brazil have been affected by market and legal forces, including Brazil's ability to produce generic ARVs.

Reviewer: Persad

Title: Clinical Trials and Medical Care: Defining the Therapeutic Misconception

First Author: Henderson, Gail E.

Citation: PLoS Medicine 2007; 4: e324-e324

Summary: An all-star team of research ethicists (including our own Christine, Frank, and Ben W.) summarize current issues surrounding the therapeutic misconception and offer a new definition. Authors also offer suggestions for how to test whether subjects have the therapeutic misconception via questionnaires.

Reviewer: Persad

Title: Sharing H5N1 Viruses to Stop a Global Influenza Pandemic

First Author: Garrett, Laurie

Citation: PLoS Medicine 2007; 4: e330-e330

Summary: During 2007, Indonesia refused to share H5N1 virus samples with the WHO, in part because the virus samples would be used to make vaccines that would primarily benefit citizens of more developed countries. Authors propose that a stockpile of vaccine (500 million doses!) be placed in Hong Kong and funded by the G8 nations plus "Asian powerhouses China, India, Singapore, South Korea, and Japan." This vaccine could be provided to Indonesians and others in Asian developing countries in a pandemic

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Science

Reviewer: Wolitz, R.

Title: In the HIV Era, and Old TB Vaccine Causes New Problems

First Author: Enserink, M.

Citation: Science 2007; 318: 1059-1059

Summary: The live vaccine used to inoculate children against TB comes with a high mortality rate for those who become infected from the vaccine and are also HIV positive. In places like Sub-Saharan Africa, logistical problems abound with determining which infants are HIV positive and secondly when to administer the TB vaccine which is typically given soon after birth.

Reviewer: Wolitz, R.

Title: Tense Meeting Produces Some hope for Flu-Sharing Deal

First Author: Enserink, M.

Citation: Science 2007; 318: 1361-1361

Summary: There has been some conflict among members of the Global Influenza Surveillance Network. “Indonesia has for the past year refused to share samples from its human H5N1 influenza victims with the network, saying those viruses are its own property and demanding guarantees that it will get the benefits—such as pandemic vaccines—that sharing can help produce” (1361). Numerous other developing countries sympathize with Indonesia, but have not taken as extreme measures. Members of GISN are still in the process of negotiating.

Reviewer: Wolitz, R.

Title: Privacy Policies Take a Toll on Research, Survey Finds

First Author: Kaiser, Jocelyn

Citation: Science 2007; 318: 1049-1049

Summary: JAMA recently published survey responses from 1500 epidemiologists. The findings indicate that 68% responded that the Privacy Rule enacted in 2003 has made conducting research a “great deal more difficult” (1049). In one particular heart disease study, the Privacy Rule slowed the recruitment process as well as created a bias towards “older, healthier, married participants” respondees.
